DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

MENTAL HEALTH PARITY FOCUSED SURVEY

FINAL REPORT

Blue Cross of California, Inc.

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Focused Survey of Blue Cross of California (the "Plan") from May 31, 2005 to June 3, 2005. A "focused survey" assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"). In this case, the Focused Survey assessed compliance of the Plan's delivery of mental health services. (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children) Blue Cross of California, Inc. was the seventh focused survey completed of seven focused surveys carried out during March–June 2005 of Knox-Keene licensed full-service plans and applicable specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full-service plan.

Health and Safety Code Section 1374.72, often referred to as the "**Parity Act**," requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and ensure the continuity and coordination of care provided to enrollees.

The Behavioral Health Division of the Plan manages the provision of mental health services for 90 percent of the Plan's enrollees. (See Appendix B)

Background

Blue Cross of California, Inc., is an independent licensee of the Blue Cross Association. It originated in 1936 as a not-for-profit hospital service organization responding to the cost of hospital care during the Depression by offering prepaid plans. By 1945, coverage for medical and surgical services was made available. In 1983, the Plan was the first California company to implement a preferred provider organization (PPO) health plan, called the Prudent Buyer Plan, contractually arranging fee discounts with thousands of physicians and hundreds of hospitals throughout the state. In 1986, the Plan introduced its health maintenance organization (HMO) plan, CaliforniaCare.

In 1993, the California Department of Corporations (now the Department of Managed Health Care) granted the Plan a license to operate as a Health Care Service Plan under the Knox-Keene Health Care Service Plan Act. The Plan restructured its operations and formed a holding company, WellPoint Health Networks Inc., which merged with, and is now a subsidiary of WellPoint, Inc. Through intermediate holding companies, WellPoint, Inc., owns the Plan, which has operated as a for-profit company since May of 1996.

The Plan has managed behavioral health services internally for its PPO membership since 1994, when the Plan acquired an employee assistance program behavioral health company. Prior to 2000, behavioral health services for the HMO products were delegated to Plan-contracted

medical groups. With the advent of mental health parity legislation, the Plan rescinded delegation of behavioral health from the medical groups and began managing behavioral health for HMO and PPO products internally. The Plan's internal behavioral health department is known as WellPoint Behavioral Health when it provides services for WellPoint managed care plans outside of California.

Survey Results

As part of the Focused Survey, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act: **Access and Availability of Services, Continuity and Coordination of Care, Utilization Management,** and **Delegation Management**.

The Department identified three compliance deficiencies in the Plan's implementation of and compliance with Section 1374.72. (See Section III, Table 1) The Plan has implemented corrective actions for these deficiencies and has corrected two of these deficiencies. One deficiency in the area of Utilization Management / Benefit Coverage remains uncorrected at the time of this Final Report and requires a Remedial Action.

Please refer to Section III for a detailed discussion of the deficiencies, the Department's findings, required corrective actions, the Plan's response and compliance efforts, and the Department's final determination regarding the status of the deficiencies.

SECTION I. FOCUSED SURVEY BACKGROUND

The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys ("Plan Surveys") conduct onsite medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full-service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed Plan Surveys to design focused surveys to review health plan compliance with enacted mental health parity laws. The project began in November 2004 and includes three phases:

(1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;
(2) Operations phase, included survey tool development and scheduling; and
(3) Conduct the surveys.

The Department supports continued discussions with stakeholders and will receive comments and suggestions throughout the project.

The purpose behind the focused surveys was to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

The Focused Survey Approach

Focused surveys give the Department the ability to swiftly respond to potential serious health plan problems, concerns, or questions raised by consumers, legislators or other Department divisions on a particular issue. Focused surveys could include assessment of compliance with newly enacted legislation, such as the Parity Act or specific applications such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal routine medical survey process, this focused survey approach allows a more detailed look at application and compliance.

SECTION II. SCOPE OF WORK

The subject of this Focused Survey is Health and Safety Code Section 1374.72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plans are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act:

- **Access and Availability of Services** – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, whether the Plan clearly communicates those terms and conditions to enrollees, and whether the Plan has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.
- **Continuity and Coordination of Care** – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.
- **Utilization Management / Benefit Coverage** – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.
- **Delegation Management** – when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies on July 18, 2005. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan (CAP) for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 1: DEFICIENCIES

#	SUMMARY OF DEFICIENCIES	Status
A. ACCESS AND AVAILABILITY OF SERVICES		
1	**The Plan has not established clear standards for after-hours care coverage and does not routinely monitor non-psychiatrist telephone and practice coverage arrangements.** [Rule 1300.67.2(b)]	Corrected
B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE		
2	**The Plan incorrectly and inappropriately denies emergency claims.** [Section 1371.4]	Not Corrected **Remedial Action**
C. CONTINUITY AND COORDINATION OF CARE		
3	**For its commercial membership, the Plan does not have a structured approach to monitor the continuity and coordination of care that enrollees receive in the outpatient setting that allows the Plan to identify and assist individuals who could benefit from structured case management to improve mental health treatment outcomes, improve coordination between medical and mental health programs, and help enrollees find needed psycho-social-environmental support not within the scope of the Plan's benefits.** [Rule 1300.74.72(g)(3)-(4)(A)]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan has not established clear standards for after-hours care coverage and does not routinely monitor non-psychiatrist telephone and practice coverage arrangements. [Rule 1300.67.2(b)]

Documents Reviewed:

- Blue Cross of California Behavioral Health Provider Accessibility Survey, Summary of Results – November 2004
- Blue Cross of California Quality Improvement Access Standards Policy

- Telephone calls to 52 participating behavioral health practitioners

Department Findings: The Plan uses an established 24-hours-a-day, seven-days-a-week standard to ensure after-hours care coverage by psychiatrists. The enrollee reaches a recorded message or live voice response providing emergency and non-emergency instructions to reach a physician.

On the initial credentialing application, the provider attests to how after-hours care is handled. As part of the credentialing process, the Plan contacts each provider after-hours to validate the provider's attestation for after-hours care. Providers must have an acceptable system in place prior to being credentialed.

The Plan monitors after-hours coverage through the North American Testing Organization **(**NATO) Provider Accessibility Survey. The survey involves a third-party vendor calling a random sample of participating psychiatrists and directly asking them a series of questions regarding accessibility. The after-hours survey question is:

Q5: How do you provide access to care outside of normal business hours?
Check all that apply:
1 = Voice mail refers patient to emergency room, 911 or a crisis hotline
2 = Answering service
3 = Pager
4 = No provision for after hours coverage*will identify the physicians and follow up
5 = Voice mail does NOT refer patient to emergency room, 911 or a crisis hotline
6 = Other_____

The Plan reported 98 percent as the most recent compliance rate for question five. When necessary, the Plan has notified individual psychiatrists and required them to submit and complete a corrective action plan.

The Plan did not present any methodology by which it directly assesses after-hours accessibility, such as calling psychiatrists' offices after hours. The Plan also did not present any documentation that it monitors the after-hours coverage arrangements and answering machine messages of nonpsychiatrist clinicians.

The Department surveyed 42 providers, including 11 psychiatrists, 7 psychologists, 7 LCSWs, 14 LMFTs, two registered nurses, and one behavioral group practice by telephone during normal business hours to assess provider responsiveness, appointment availability, and whether the practice was open to new patients (see Table 2 below). If the provider or provider staff did not answer the call, the Department assessed whether:

- An answering machine message or service was in place;
- The message contained a pager number or answering service by which the enrollee could reach the provider; and
- Instructions directed callers to contact 911 or what to do in the event of an emergency.

The Department also left a message requesting a return call and monitored whether a return call was received within 24 hours. The Department found that a "live person," either the provider or office staff, answered 15 of the calls. The other 26 offices had automated answering systems in place and one had an answering service. Of the 26 with answering machines, 19 contained emergency instructions to contact either 911 and/or other emergency instructions, including provider pager numbers, local crisis response teams or dialing another specified number for help. Some included both. However, these messages were inconsistent; seven practitioners gave no emergency instructions.

Of the 27 providers for whom messages were left (i.e. who were not on vacation and had operational messaging systems), 14 responded with a return call within 24 hours; the remainder did not.

The Department also performed an after-hours telephone survey of 10 providers, including three physicians, three psychologists, two LCSWs, and two LMFTs to assess the presence and content of answering service/machine messages. Three of the calls were answered by a provider; the remaining seven were answered by machines. Of these, only four provided emergency instructions.

Thus, only 23 of the 33 messages of providers included in the Department's survey during and after business hours included some type of emergency instruction.

TABLE 2: TELEPHONE SURVEY OF PROVIDERS

TOTAL CALLS					If Not Answered By Provider/Staff				If Contact With Provider Or Office Staff	
						If Answering Machine:				
Type of call	Answered by provider or office staff	Not answered by provider or office staff	Message left Call back with-in 24 hours	Total Contacts with provider or office Staff	Answering machine (M) or answering service (S)	Machine directed enrollee to 911	Additional emergency instructions (e.g., pager, crisis line, crisis center)	Total with 911 and/or other emergency instructions	Open to new patients	Meets Plan's Routine Appointment Availability Standard of 10 Working Days
Calls during business hours	15 36% N=42	27 64% N=42	14 52% N=27	29 69% N=42	M = 26 S = 1 N=27	16 62% N=26	12 46% N=26	19 73% N=26	24 80% N=30**	20 69% N=29
Calls after hours	3 30% N=10	7 70% N=10	NA	3 30% N=10	7 100% N=7	4 57% N=7	2 29% N=7	4 57% N=7	NA	NA

** 3 of the 4 answering service calls were initially answered by machine; 2 of those 3 had 911 instructions

Implications: Access to individual providers both during and after business hours must be ensured, and clear instructions given via provider messaging systems regarding how enrollees may contact the provider and/or other sources of assistance. The Plan currently monitors the after-hours availability and messaging instructions for psychiatrists. It is equally important to monitor the availability of psychologists and master's-prepared clinicians who make up the

majority of the Plan's providers. Additionally, to facilitate prompt handling of current patients' needs, and expeditious responses to calls for new appointments, the Plan must ensure that all providers respond in a timely manner to messages left for them by either members or the Plan.

Corrective Action: The Plan shall provide evidence that it has developed and distributed to all of its providers clear and detailed instructions regarding its requirements for messaging and after-hours telephone coverage.

The Plan shall also provide evidence that it has established a system for monitoring the presence and content of provider answering system messages and the timeliness of providers' responses to messages left by enrollees.

Plan's Compliance Effort: The Plan stated that it has revised its policy regarding accessibility and availability to establish clear standards for after-hours coverage for its behavioral health providers. The revisions were approved at the July 12, 2005 Quality Management Strategic Planning Committee meeting. The changes to the policy included clarification that after-hours access standards applied to all behavioral health providers. Newsletter articles will communicate the change and notify providers that the standards will be monitored.

The Plan is notifying its providers of the access standards, including the after hours requirements using the following mechanisms:

- Draft of Fall 2005 Provider Newsletter Article *(Attachment #3)*
- Provider Operation manuals
- Annual survey of open and closed practices
- At Initial Credentialing and Re-credentialing

The monitoring methodology for after-hours coverage was changed to replicate that which is used by the Plan to monitor after-hours coverage of primary care physicians. This new methodology has been used for a number of years by Knox-Keene licensed plans who participate in the California Cooperative Reporting Initiative/Pacific Business Group of Health's annual PCP and specialist access survey. It incorporates the current practice of surveying providers' offices during regular hours, which incorporates various elements, including (1) asking providers to attest to their after hours coverage, and (2) making additional after hours test calls to a sub-set of this group.

This change in methodology will be implemented in the Plan's 2005 Behavioral Health Access Survey and will be conducted by the North American Testing Organization (NATO) in the 4th quarter. The survey will be done using a statistically valid sampling of the Blue Cross Behavioral Health Network. This NATO survey has always included psychiatrists and other allied mental health professionals.

As an additional monitor, after-hours survey questions will be added to the annual survey of "open/close practice" status that is conducted by Plan staff. In the past, this ongoing survey was limited to all psychiatrists but methodology will now be changed to include a statistically valid

sample of non-psychiatric therapists. This survey will be performed in the spring of 2006. Additional after-hours test calls will be placed to a sub-set of this group.

The Plan will also conduct compliance education with providers who were found to be out of compliance at the time of the Mental Health Parity Focused Survey ("Focused Survey"). In addition, after-hours calls will be made to these same providers to determine subsequent compliance. Education will continue to be provided to all providers found to be out of compliance by any of the Plan's monitoring mechanisms, including member complaints.

The Plan submitted the following documents:

- Copy of July 12, 2005 Quality Management Strategic Planning Committee meeting Agenda.
- Copy of Revised policy 25

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been corrected.

The Plan has made appropriate revisions to its Policy 025, Access Standards, and plans to communicate the information regarding the new after-hours requirements to its providers via varied distribution mechanisms. The Plan has proposed acceptable approaches for monitoring both after-hours arrangements and provider responsiveness to enrollee messages. As part of its next Routine Survey, the Department will review the implementation and results of the Plan's monitoring. The Department will also review the notification of providers regarding access standards in the following mechanisms:

- Fall 2005 Provider Newsletter Article
- Provider Operation manuals
- Annual survey of open and closed practices
- At Initial Credentialing and Re-credentialing

B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE

Deficiency 2: The Plan incorrectly and inappropriately denies emergency claims. [Section 1371.4]

Documents Reviewed:

- Emergency service claims from October 2004 through March 2005

Department Findings: The Department reviewed a total of 19 ER claims from non-participating providers and 19 from participating providers. Twelve of the 19 claims from non-participating providers were from county facilities. The Department found that the Plan inappropriately denied 23 of the claims reviewed.

The Department's findings are summarized below:

TABLE 3: EMERGENCY ROOM (ER) CLAIMS DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	#COMPLIANT	#DEFICIENT
Par ER Claims	19	Appropriate denial	10	9
Non-Par ER Claims	19	Appropriate	5	14
County Facility	12	Appropriate denial	3	9
Total Claims	38		15	23

The Plan's claims examiners refer to an "auto pay" list when processing ER mental health claims, as is done when processing medical emergency claims. This list contains certain diagnoses, revenue codes and procedure codes that are deemed automatically payable without the benefit of a medical review. In addition, there are established guidelines examiners must follow when processing claims. Specific to ER claims, the following are the Plan's guidelines:

- The examiner shall apply the prudent layperson rule;
- The examiner shall automatically pay claims with emergency revenue codes of 450-459 or CPT codes 99281-99285 and 99288 regardless of diagnosis and participation of provider (these claims do not require authorization nor medical review and are automatically paid);
- The examiner shall automatically pay professional claims related to a paid ER facility claim;
- The examiner shall refer all claims for in-patient hospitalization (regardless of mode of admission, e.g., via ER) for review of medical necessity if the facility did not obtain an authorization for the in-patient stay;
- The examiner shall not automatically deny a claim from a non-participating provider. The examiner shall determine whether the claim should be referred for medical necessity review or whether additional information is needed; and
- The examiner shall refer a claim to medical review if the service performed is a medical procedure but the diagnosis is mental health. The purpose of the review is to determine what benefit (medical vs. mental health) will be applied.

The Department found a number of inappropriate denials including those stemming from the failure of examiners to follow established guidelines as demonstrated in the examples below:

Claims from non-participating providers:

1. Claim #1- a county facility claim with attached medical record (MR) clearly indicating the enrollee was admitted under 51/50 (involuntary admission of a patient). The claim was denied citing the reason "all inclusive," which means the Plan had already paid the entire claim by a contractual agreement that all services in a given day be paid on a "per diem" basis. Such payment arrangement is common between a plan and its contracted/participating facility providers but not with non-participating providers. The examiner should have referred the claim to medical review for determination of medical necessity.

2. Claim #2 – a county facility claim with a revenue code "920," which is a code used by county facilities in place of code 450. The Plan denied the claim citing denial reason "revenue code invalid." The Plan's claims system is programmed to alert the examiner to default to code 450 when a claim contains the revenue code 920 so that the claim can be paid automatically. In this instance, the examiner failed to heed the system alert. One other county claim was inappropriately denied with the same type of error.

3. Claim#3- a county facility claim with code 450 and with attached medical record clearly indicating a 51/50 admission. This claim was denied as "not a covered benefit (denial code R050180)." This denial reason is used when the billing/rendering provider is a non-participating provider. Under HMO benefits, a service is not a covered benefit if rendered by a non-participating provider. Claims processing guidelines indicate that claims from non-participating provider shall not be denied without the benefit of a medical review. In addition, a claim with code 450 shall be paid automatically. In this instance, the examiner followed neither of these guidelines.

4. Claim#4- a county professional claim was denied as "PMG liability." Per contract with the PMG, this is Plan's liability. The related hospital claim was also inappropriately denied with incorrect denial reason "not a covered benefit (denial code R050180)." Both claims were readjusted for payment on 5/10/05 as a result of this Focused Survey.

5. Claim #5- a county professional claim with attached 5150 report was received on 10/07/04 and denied on 10/08/04 with denial code R50180 —"not a covered benefit." Plan reprocessed the claim as a result of this Focused Survey.

Claims from participating providers:

1. Claim#6- a facility claim submitted electronically (EDI) with code 450. Claim was received on 4/15/04 and denied on 10/25/04 citing denial code R50180 "this is not a covered benefit."

2. Claim #7- another EDI facility claim received on 12/16/04 and denied on the same day citing denial code R50180 "not a covered benefit." The Plan reprocessed the claim on 5/31/05 with a new and correct denial reason: "this is a carve out benefit" The EOB appropriately stated: "claim should be forwarded to UBH." This claim was reprocessed as a result of this Focused Survey.

The Plan staff acknowledged the errors and stated that their claims system is undergoing some enhancements to improve the processing of mental health parity claims. It is not known when these system enhancements will be completed.

Implications: Incorrect denial of payment for health care services to which enrollees are entitled breaches the agreement between the enrollee and the Plan for covered services, may create a barrier to future services based on previously denied payments, and may result in providers inappropriately billing enrollees for these services.

Corrective Action: The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures. This internal audit program shall include the following features.

- The audit report shall include, but not be limited to:
  - Total number and percent of ER claims that qualified for automatic payment;
  - Total number and percent of ER claims that qualified for and were automatically paid;
  - Total number and percent of ER claims that were referred for medical review; and
  - Accuracy of medical review determination, based on statutory requirements.
- Files selected for audit shall include appealed cases as well as initial determinations.
- The file sampling method shall be proportional to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20 percent of the Plan's total ER claims, then 20 percent of the ER claims selected for audit should be from county facilities.
- The Plan shall establish an implementation date for the audit program no later than two months from the date of this Preliminary Report, and shall include the implementation date in its response to this Preliminary Report. Audit results shall be reported to the Department within a reasonable timeframe, after three and six months of the implementation date.

Plan's Compliance Effort: On August 8, 2005, representatives of the Plan had a telephone conference with representatives of the Department to clarify the design of the internal audit the Plan must conduct and the time within which the Plan must report results of that audit. In that conference, the Plan proposed providing the Department with detailed written specifications of its audit design, which would incorporate the Preliminary Report's stated criteria, by written response no later than September 18, 2005. Additionally, the Plan proposed that, at quarter's end, it would draw the quarterly sample, conduct an audit and within a reasonable number of days after the quarter end, submit a written report to the Department. Under the paragraphs below entitled **Reporting** and **Schedule,** details are outlined regarding the reports the Plan will make in complying with this corrective action, and the date reports will be submitted.

The Plan provided the following summary description of its Audit Plan.

Audit Plan

The Customer Quality Review department in BCC Finance will implement an audit program to monitor compliance of claims administration according to Plan policies and procedures independent of BHA and claims operations. The audit will begin with claims processed during third quarter 2005.

The program will consist of three audits and a performance improvement process.

1. Denied MHP claims

A sample of 50 - 100 claims billed with the "parity" diagnosis codes and denied for benefit reasons will be reviewed to determine accuracy. If errors are found the audits will continue until processing is corrected. The sampling method will be proportional to the types of billing facilities.

2. Denied ER MHP claims

A sample of 75 to 125 claims billed with "parity" diagnoses and denied for benefit reasons will be reviewed to determine accuracy each quarter beginning with third quarter 2005. The sampling method will be proportional to the types of billing facilities.

3. ER MHP Appeals

A sample of appeals from members or providers regarding denied ER parity claims will be reviewed quarterly to determine accuracy. If errors are found, the audits will continue until processing is corrected. The sample size will vary depending on the number of cases on file.

4. Performance Improvement

All exceptions found in the three audits will be verified by Operations and BHA Management. Operations VPs accountable in Individual and Small Group, Large Group, State Sponsored and Senior divisions will determine the appropriate corrections to system programming and processing policy and procedures.

All sampled claims involving medical or clinical review will be re-assessed by the Associate Medical Director Behavioral Health Quality management. This physician will work with BHA Quality Compliance and Claims Operations management to implement any corrections needed to clinical processing.

Audit criteria

Auditors' review will include, but not be limited to:

- Denial correct
- Reason for denial correct
- Referral to medical review correct, if any

- Medical review correct, if any
- Processing of claims followed MR correctly, if any
- Application of Late Payment Penalties correct, if any required

Reporting

The Plan shall extract statistics quarterly from processed claims files for the purpose of analyzing certain ER MHP patterns:

- Number and percent of ER MHP claims automatically paid
- Number and percent of ER MHP claims denied for benefit reasons, if any.
- Number and percent of ER MHP claims referred for medical review, if any.
- Number and percent of claims from participating facilities
- Number and percent of claims from County facilities
- Number and percent of claims from other facilities
- Number and percent of appeals from members
- Number and percent of appeals from providers

The audit will determine the estimated percent of cases processed correctly for each of the segments defined. All exceptions will be documented for review and corrective action.

Reports summarizing the findings and corrective actions will be submitted to DMHC for processing of claims during third quarter and fourth quarter 2005.

Schedule

The Plan's CQR unit will develop the detailed program requirements by September 18, 2005. The design and programming of data extracts and samples are scheduled for October 15, 2005. The audits are scheduled for October 15 through November 30, 2005.

Exception verification and correction action planning will occur by December 5.
The Plan will submit a summary report to DMHC by December 15, 2005. A similar schedule will produce an audit assessment and summary report covering fourth quarter 2005 no later than February 28, 2006.

Additionally, the Plan has taken steps to ensure a degree of communication and coordination between BHA clinical operations in San Diego and the Plan's claims operations, grievance and appeal and customer service units located in Los Angeles and Ventura County. During the third quarter of 2004 the Plan initiated a project in its Grievance and Appeal unit known as "Top 3." The goal of this project was to identify the top three grievance issues being resolved in favor of the member, conduct root cause analysis and implementation of action plans to decrease volume of the top three issues, followed by re-measurement.

Inaccuracy of claims payment was the number one issue identified. More than 15 system enhancement issues were put into place in the six months following implementation of Top 3. In addition, policies were revised and customer service/claims operations retraining occurred. Part of the commitment of the Top 3 project is to conduct follow-up measurements of performance to track on-going effectiveness of the action plan and to identify other issues that may arise.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has proposed a thorough, responsive and reasonable claims audit program. The Plan will commence design and programming of data extracts and samples on October 15, 2005. However, the Plan has not had sufficient time within the 45-day response period to fully implement its auditing procedures and provide audit results to demonstrate the effectiveness of the Plan's corrective actions.

REMEDIAL ACTION: The Plan is to submit its first summary results to the Department with 30 days upon receipt of this Final Report. Once the review is complete, the Department will inform the Plan of any further action to be taken to fully correct this deficiency.

C. CONTINUITY AND COORDINATION OF CARE

Deficiency 3: For its commercial membership, the Plan does not have a structured approach to monitor the continuity and coordination of care that enrollees receive in the outpatient setting that allows Plan to identify and assist individuals who could benefit from structured case management to improve mental health treatment outcomes, improve coordination between medical and mental health programs, and help enrollees find needed psycho-social-environmental support not within the scope of the Plan's benefits. [Rule 1300.74.72(g)(3)-(4)(A)]

Documents Reviewed:

- Twenty case management files
- Policy #045 – Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in the Primary Care Setting
- Policy #047 – Appropriate Treatment & Follow-Up of Members with Coexisting Medical and Behavioral Health Disorders
- QI Policy #032 – Monitoring Oversight of Continuity and Coordination of Care

Department Findings: While the Plan's open access model for its commercial population provides easier access for enrollees and less paperwork for providers, it limits the Plan's ability to identify opportunities that ensure continuity and coordination of care. Utilization management

activity is limited to episodes of inpatient/intensive treatment. Case management activity is evident only for enrollees in Healthy Families and Police Officers Research Association of California (PORAC) benefit plans, both of which require prior-authorization and approval of outpatient treatment plans.

In interviewing staff members and reviewing policy documents, the Department could not find any evidence of the use of program criteria or "triggers," such as multiple admissions in a specific timeframe or psychopharmacologic treatment without medication management visits that would alert staff members to the potential need for case management. The majority of enrollees receiving behavioral health services would not come to the attention of behavioral health division clinical staff.

Utilization management staff members do not appear to have clear involvement in efforts to identify and assure adequate treatment of enrollees with coexisting medical disorders. Even among Healthy Families enrollees who receive the highest level of utilization and case management, five of thirteen inpatient cases reviewed showed an Axis III diagnosis of asthma without evidence of attempts to address this coexisting condition. Case management staff members do not appear to work directly with their peers on the medical side or play a direct role in contacting a medical provider to assure follow-up of medical issues.

Corrective Action: The Plan shall provide evidence that it has implemented a system to monitor the continuity and coordination of care that enrollees receive across the health care network and identify those enrollees who would benefit from case management to improve continuity and coordination within the behavioral health system and between the behavioral health system and the medical health system.

Plan's Compliance Effort: The Plan stated that it currently has a variety of quality improvement activities that address continuity and coordination of care. These activities specifically address such issues as co-existing chronic medical illnesses and depression, psychotropic medication monitoring between co-treating practitioners, and antidepressant compliance. The Plan also employs a Transition Assistance Team to actively facilitate continuity and coordination of care for new enrollees and assist when a contracted provider leaves the network. These activities, and the expectation that medical and behavioral health practitioners routinely coordinate care, are regularly communicated to the practitioners through operation manuals, network newsletters and clinical practice guidelines. The Plan then measures the degree of exchange of information between providers by surveys and chart audits. Expansion efforts are now underway to promote structured continuity and coordination of care in the outpatient setting. These specific activities are as follows:

1. <u>Enrollee Identification</u>

The Plan is now actively engaged in expanding the early identification of potential enrollees for participation in intensive behavioral health case management activities and existing medical health improvement programs. These expansion efforts will specifically involve predictive modeling and expanding efforts during the utilization review process to identify enrollees with potentially related medical conditions.

Toward this end, existing efforts to measure and analyze demographic data and disease prevalence will be expanded. Sophisticated software will be employed to identify individual

enrollees who might benefit from proactive assistance from the Plan. This software, Care Enhanced Resource Management System (CRMS), will analyze claims data and use predictive modeling logic to identify specific enrollees for voluntary inclusion in Behavioral Health's expanded case management programs.

The existing inpatient utilization management processes will also be leveraged to improve the identification of members with co-existing medical conditions and promote coordination of care. Medical conditions with a potential likelihood of impacting the enrollee's mental health condition will be identified by the Plan's Specialty Case Managers and proactive linkage, as appropriate, will occur with related health improvement programs. These programs will specifically include congestive heart failure, asthma and diabetes.

Additionally, protocols and training are being developed to assist the Specialty Case Managers who conduct utilization management with the identification of relevant medical disease states and medications that mimic psychiatric symptoms and the effects of psychiatric medications. The Specialty Case Managers who identify enrollees with potential risk factors can refer to existing health improvement programs and will consult with the Plan's Physician Reviewers for further evaluation and interventions.

2. Medical Management Interface Tool

Active efforts are underway for the launch of a new interface within the existing medical management software and important utilization data. This interface, known as the "MAS Toolbar," will allow Plan staff to quickly identify enrollees who are currently engaged in treatment and provide a vehicle for instantaneous referrals between the medical case management and behavioral health programs. Implementation of the MAS Toolbar is slated for the fourth quarter of 2005.

3. Behavioral Health Intensive Case Management

The Plan will be instituting a Behavioral Health Intensive Case Management program to identify potential enrollees for expanded assistance with continuity and coordination of care. The goals of the program will include:

- Identification of high risk patients who may benefit from coordination of care
- Improved mental health treatment outcomes
- Improved communication and coordination between and among medical and behavioral case managers, behavioral health providers, and PCPs
- Facilitate linkage to psycho-social-environmental support in the community.

The program will have medical oversight from the Behavioral Health Medical Director and programmatic oversight from the Utilization Management department. The Case Managers will be responsible for assisting a selected group of enrollees and their treatment providers with early identification of needs, proactive engagement with appropriate preventative care/services and promoting communication between co-treating practitioners. Their efforts will be particularly

focused on promoting active psycho-social-environmental support and collaboration between behavioral health and medical practitioners.

The launch of the Intensive Case Management program is anticipated within the fourth quarter of 2005.

4. Expanded Health Improvement Programs

The Plan will be instituting an expanded health improvement aimed at identification of enrollees who are at risk for metabolic syndrome. This program will identify enrollees who have been on atypical anti-psychotics for an extended period of time and provide feedback to both the individual and their prescribing physician of the potential medical complications such as diabetes and cardio-vascular disease. Launch of this new initiative is projected for the first quarter of 2006.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been corrected.

The Plan's proposed activities to expand its current efforts and promote structured continuity and coordination of care in the outpatient setting appear reasonable.

D. SURVEY CONCLUSIONS

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

A P P E N D I X A

METHODOLOGY & PARAMETERS

A. Review Methodology

The Department conducted a Focused Survey of the Plan from May 31, 2005, to June 3, 2005, at the Plan's behavioral health offices in San Diego, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey utilizing the clinical expertise of a psychiatrist, a registered nurse, and a psychologist.

Survey activities included the review of plan documents, enrollee case files, and claims. The Surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 52 participating providers to assess appointment availability and evaluate the providers' after-hours telephone message in regard to the provision of emergency services. Each survey activity is described in greater detail below.

Review of Plan documents – The Department reviewed a number of additional materials to assess various aspects of Plan compliance, for example:

- Policies and procedures for all related activities
- Internal performance standards and performance reports
- Communications explaining coverage and benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits, and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities, and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

Review of enrollee case files: Prior to the onsite visit, the Department requested logs for a number of Plan activities, e.g., utilization review, claims processing, case management, etc. From these, the Department selected samples of case files for a comprehensive review. Review focused on measures such as appropriateness of denials of services, timeliness of decision-making, and coordination of care, as well as the appropriate exchange of information among providers.

Initially, the Plan stated that it did not have any benefit denials. On further inquiry the Plan stated that a number of inquiries about covered services and denied claims for out-of-network services for which the member or provider did not request prior-authorization that are initially handled by Customer Service result in an enrollee complaint or appeal of the denied claim. These

complaints/appeals are forwarded to the behavioral health division for review, investigation, and resolution. The Department reviewed 18 of these complaints/appeals, two of which resulted in denials.

All file reviews were performed with the participation of Plan staff. Table 4 below displays the categories of utilization management files reviewed and the sample sizes selected.

TABLE 4: FILES REVIEWED

CATEGORY OF FILE	SAMPLE SIZE
Utilization Management - Medical Necessity Denials for Persons with Autism and Other PPD diagnoses and services for SED children	16
Utilization Management - Medical Necessity Denials for Persons with Other Parity Diagnoses	23
Utilization Management-Benefit Denials	2
Utilization Management - Denials of Non-Formulary Pharmaceuticals	10
Continuity and Coordination of Care – Case Management Files	20

Review of claims – Prior to the onsite visit, the Department requested claims listings. From these, the Department selected samples of claims for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. The review of claims files was performed with the participation of Plan staff. Table 5 below displays the categories of claims reviewed and the sample sizes selected.

TABLE 5: CLAIMS FILES REVIEWED

CATEGORY OF CLAIM	SAMPLE SIZE
Claims for emergency services from nonparticipating providers	19
Claims for emergency services from participating providers	19

Interviews – The Department interviewed staff from both the Plan and Delegate to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims, and documents the Department reviewed. The list of individual officers and staff members interviewed, along with their respective titles, may be found in Appendix C. The list of the Department's survey team members who conducted the interviews may be found in Appendix D.

B. Utilization Management File Review Parameters

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses
- Accuracy of case categorization (parity vs. non-parity)
- Decision rendered/action taken by plan (approval or denial)
- Adequacy of clinical information obtained to support decision-making
- Documentation of rationale supporting the decision rendered
- Accuracy of decision based upon statutory requirements, and
- Consistency between decision and communication sent to the affected practitioner/provider and member

C. Claims Review Parameters

The parameters assessed during the review of claims included:

- Diagnoses
- Accuracy of claim categorization (parity vs. non-parity; participating vs. nonparticipating; and emergency vs. non-emergency)
- Adequacy of administrative and clinical information obtained to support denial decision-making
- Appropriateness of denial
- Documentation of referral to medical review prior to denial decision rendered
- Accuracy of documented denial reason based upon plan policies regarding claim processing
- Accuracy of payment based on mandated parity benefits, and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee

A P P E N D I X B

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

Tables 6 through 8 below summarize the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

TABLE 6: PLAN PROFILE

Type of Plan	**Full Service Plan**	
Enrollees who Receive Services through the Behavioral Health Division of Blue Cross of California and Specialized Health Care Service Plan(s) or Mental Health Plan(s) with which the Plan Contracts for Provision of any Section 1374.72 Services as of May 1, 2005	**Organization**	**Enrollees**
	Blue Cross of California	4,039,918 (90%)
	United Behavioral Health	212,864 (5%)
	MHN and the Holman Group	134,667 (3%)
	Value Behavioral Health	8,688 (0.2%)
	PacifiCare Behavioral Health	19,114 (0.4%)
	CIGNA Behavioral Health	47,786 (1%)
	Magellan Behavioral Health	4,345 (0.1%)
	Other	6,950 (0.2%)
	Total	**4,474,332**
Number of Enrollees Covered by Mental Health Parity as of May 1, 2005	**Product Lines**	**Enrollees**
	HMO, POS	1,440,036
	Healthy Family HMO	116,761
	Healthy Family EPO	150,041
	PPO Commercial	2,767,494
	Total	**4,474,332**

Blue Cross Preferred Provider Organization (PPO) Service Area	Alameda Alpine Amador Butte Calaveras Contra Costa Colusa Del Norte El Dorado Fresno Glenn Humboldt Imperial Inyo*	Kern* Kings Lake Lassen* Los Angeles Madera Marin Mariposa Mendocino Merced Modoc Mono Monterey Napa	Nevada Orange Placer Plumas Riverside* Sacramento San Bernardino* San Benito San Diego San Francisco San Joaquin San Luis Obispo San Mateo Santa Barbara	Santa Clara Santa Cruz Sierra Siskiyou Solano Sonoma Stanislaus Sutter Tehama Trinity Tulare Tuolumne Ventura Yola Yuba
Blue Cross Point of Service (POS) Service Areas	Alameda Butte Contra Costa El Dorado* Fresno* Imperial* Kern* Kings Los Angeles* Marin	Merced Nevada* Orange Placer* Riverside* Sacramento San Benito* San Bernardino*	San Diego* San Francisco San Joaquin San Luis Obispo San Mateo Santa Clara Santa Cruz Solano	Sonoma* Stanislaus Yolo Humboldt Madera Santa Barbara Tulare Ventura
Blue Cross HMO Service Area	Alameda Butte Contra Costa El Dorado* Fresno* Humboldt Imperial* Kern*	Kings Los Angeles* Madera Marin Merced Nevada* Orange Placer*	Riverside* Sacramento San Benito* San Bernardino* San Diego* San Francisco San Joaquin San Luis Obispo San Mateo	Santa Barbara Santa Clara Santa Cruz Solano Sonoma* Stanislaus Tulare Ventura Yolo
Blue Cross Power Select HMO Service Area	Alameda Contra Costa Fresno Imperial Kern Los Angeles*	Merced Nevada* Orange Placer* Riverside* San Francisco	San Joaquin San Mateo Sacramento San Bernardino* San Diego*	Santa Clara Santa Cruz Stanislaus Tulare Yolo

*Partial county

Plan Identification of Enrollees Eligible for Parity Services
Adults: Because the Plan anticipates full parity occurring in the future and because the Plan's claims processing system cannot identify the age of the enrollee who received the services listed on the claim, which impacts the SED determination, the Plan has chosen to provide parity benefits to anyone that has an ICD-9-CM diagnosis for which there is a comparable diagnosis in the DSM-IV-TR, other than for substance abuse.
Seriously Emotionally Disturbed Children: The Plan considers SED any child under the age of 18 who has an ICD-9-CM diagnosis comparable to the DSM-IV-TR diagnosis, other than for substance abuse and developmental disorder. Additionally, providers may contact Blue Cross of California and request the SED designation based on the member's meeting the criteria as set forth in Welfare and Institutions Code 5600.3. The designation is then entered into the claims system allowing for payment at the parity level of reimbursement regardless of the diagnosis on the claim. For Healthy Families children the Plan provides routine outpatient treatment plan review. Elements within the treatment plan allow for proactive screening of children and adolescents for SED. Whenever screening criteria appear to be met, the Plan initiates follow-up with the treating providers and arranges for appropriate assessments. If the enrollee appears to be SED, the Plan refers the enrollee to the appropriate county mental health system for SED evaluation, outpatient care, and hospital care beyond 30 days per year.

TABLE 7: MENTAL HEALTH PROVIDER NETWORK

Practitioners That Treat Adults	Number in the Network
Psychiatrists	1,270
Doctoral-level psychologists	1,471
Mental health nurse practitioners with furnishing numbers	0
Other mental health nurse practitioners	12
LMFTs	1,921
LCSWs	969
Total	**5,643**

Practitioners That Treat Children and Adolescents	Number in the Network
Psychiatrists	566
Doctoral-level psychologists	1,092
Mental health nurse practitioners with furnishing numbers	0
Other mental health nurse practitioners	10
LMFTs	1,606
LCSWs	780
Total	**4,054**

Programs and Institutional Providers That Treat Adults	Number in the Network
Acute inpatient units—voluntary admissions	377
Acute inpatient units—involuntary admissions	Information is not tracked separately
Crisis treatment centers/programs	373
Intensive outpatient treatment programs/partial hospitalization	156
Residential treatment programs	57
Eating disorder programs	120
Programs and Institutional Providers That Treat Children and Adolescents	**Number in the Network**
Acute inpatient units—voluntary admissions	305
Acute inpatient units—involuntary admissions	Information is not tracked separately
Crisis treatment centers/programs	302
Intensive outpatient treatment programs/partial hospitalization	90
Residential treatment programs	19
Eating disorder programs	105

TABLE 8: ACCESS AND AVAILABILITY STANDARDS

Availability Standards					
Type of Practitioner	**Ratio of Practitioners to Enrollees**	**Geographic Availability**			**Percent of Open Practices**
		Urban	**Suburban**	**Rural**	
Psychiatrists	The Plan does not have any standards for the ratio of practitioners to enrollees. Psychiatrists are included in the overall Plan standard of one specialist per 1200 enrollees.	2 within 5 miles Goal is 85%	2 within 8 miles Goal is 85%	1 within 15 miles or 30 minutes Goal is 85%	No standard
Doctoral-level psychologists		2 within 5 miles Goal is 85%	2 within 12 miles Goal is 85%	1 within 15 miles or 30 minutes Goal is 85%	
Mental health nurse practitioners with furnishing numbers					
Master's-prepared therapists					

Appointment Availability Standards	
Type of Services	**Standard**
Non-life-threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial Post-hospitalization Follow-up Visit	Within 7 days
Routine Visit	Ten working days
Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral	BCC does not require triage and referral. The standard for Behavioral Health Intake is 80% of calls answered by a live person in less than 30 seconds.
Triage and Referral Abandonment Rate	The standard for Behavioral Health Intake is less than 5%
Member Services Average Speed of Answer	80% of calls are answered by a live person in less than 30 seconds.
Member Services Abandonment Rate	Less than 5%

B. Overview of Programs

Table 9 below presents a brief overview of the Plan's operations in each of the four program areas examined during the Department's focused survey.

TABLE 9: OVERVIEW OF PROGRAMS

PROGRAM	DESCRIPTION
ACCESS AND AVAILABILITY	• The Plan's HMO and PPO Evidence of Coverage (EOC) documents accurately and clearly describe benefit coverage for mental health parity diagnoses/conditions (including severe mental illness, and severe emotional disturbance of a child). In addition, the EOCs distinguish between parity and non-parity diagnosis mental health benefits and describe how enrollees can obtain both parity and non-parity benefits. Enrollees access care in the same manner, regardless of their diagnosis/condition. • With the implementation of AB 88, the Plan determined that in behavioral health residential treatment centers coverage is comparable to medical skilled nursing facility coverage. Therefore, for each contract with a skilled nursing facility benefit, the Plan provides an equal level of coverage for residential treatment facilities for behavioral health conditions. • The Plan has established geographic standards for psychiatrist and

ACCESS AND AVAILABILITY

nonpsychiatrist providers (see above). The Plan presented the following measurements of provider availability in the presite visit questionnaire.

Type of Practitioner	Ratio of Practitioners to Enrollees*	Geographic Availability	Percent of Open Practices**
Psychiatrists	1:3,108	91.3%	82.63%
Doctoral-level psychologists	1:2,683	95.3%	98.06%
Master's prepared therapists	1:1,366	97.0%	98.78%

*The Plan does not have standards for the ratio of practitioners to enrollees or the percent of open practices.
* *The Plan uses several means to capture these data, including but not limited to annual telephone surveys of psychiatrists, postcard surveys, provider update processes, etc.

- The Plan uses the following processes to verify periodically that participating providers are accepting new enrollees and takes this information into account when monitoring the adequacy of its network:
  - All providers have received instructions contractually and through the provider newsletter to communicate with the Plan whenever practice status changes.
  - When providers call in to update any aspect of their practice, they are asked about open/closed practice status.
  - In addition, the Plan conducts an annual telephone survey of psychiatrists to determine open practices. The 2005 telephone survey of 1,141 psychiatrists determined that 72% have open practices.
- Enrollees with autism have open access to behavioral health services, including diagnosis and evaluation services, psychological testing, individual, family, and group therapy.
  - Speech, language, and occupational therapy are the responsibility of the Plan's medical management programs for enrollees whose primary care physicians directly contract with the Plan and of the medical groups for those enrollees whose primary care physician is in a capitated medical group.
  - The Plan behavioral health medical director queried the Plan's medical management to find out if problems exist with authorization of speech and language therapy and occupational therapy for enrollees with autism. Plan medical management staff reported some problems with medical groups not authorizing therapy over an extended period of time initially, but the Plan had done training with medical group UM staff about the appropriate length of time for therapy for a child with autism. The Plan behavioral health medical director also reported no appeals of denied requests for speech and language therapy or occupational therapy for

	enrollees with autism for the past year. • The Plan provides treatment for eating disorders through inpatient programs, intensive outpatient programs, and residential treatment programs. The Plan has identified a need for better-structured eating disorders programs, particularly residential treatment programs and full-day partial hospitalization programs with supervised meals.
UTILIZATION MANAGEMENT	• The Plan does not provide utilization management for any ambulatory services except for two accounts, Healthy Families and PORAC. These two accounts comprise less than 200,000 of 5 million covered lives, less than 4 percent. The Plan reviews Behavioral Health Treatment Plan Forms (BHTPF) that providers use to request both initial and ongoing ambulatory treatment. Six initial visits that can be approved for Healthy Families, and 12 for PORAC. After the initial visits the requesting provider may submit a follow-up BHTPF to request further visits. The Plan approves additional visits based on the information in the BHTPF. For all other accounts, the Plan provides open access to outpatient services. • Institution-based services are managed for all enrollees. This includes inpatient hospitalization, partial hospital programs, intensive outpatient programs, and residential treatment centers. Prior authorization, concurrent review, and retrospective review are required for these care settings. The Plan provides telephone utilization management but not onsite review for all institution-based services. Only emergency admissions to inpatient services do not require authorization. • The Plan covers all involuntary (5150) admissions for 72 hours without authorization. All emergency admissions that occur during non-business hours are automatically authorized until the next business day. After 72 hours for 5150 enrollees and on the first business day following an emergency admission, the Plan provides concurrent review if further care is requested. • All requested services are reviewed against the Plan's internally developed medical necessity criteria. The Plan also provides discharge planning to assist in the coordination of care between the inpatient and outpatient settings. Claims are reviewed retrospectively against the medical necessity criteria for payment. • The Plan requires prior-authorization for Provigil and antipsychotics/neuroleptics for children age six years and younger to ensure safety. The Plan has denied all requests for Provigil for enrollees with a parity diagnosis for which the drug has been requested based on its investigational nature for the indications requested. The Plan has not denied any requests for antipsychotics/neuroleptics for children age six years and younger.

CONTINUITY AND COORDINATION OF CARE	• Plan policies, provider manuals, and provider newsletters promote the coordination of care message. The Plan's open access model and limited case management role reduce opportunities for direct involvement in the coordination of mental health treatment. Interventions, including a Post-Hospitalization-Home Health pilot, have attempted to increase the number of patients linked with outpatient treatment following discharge. • The Plan sets clear expectations in policy statements and provider manuals that mental health providers are to exchange information with medical providers. Mental health providers are required to request that enrollees sign a Release of Information to be placed in their chart to allow medical providers to discuss enrollees' mental health. PCP Provider Satisfaction Surveys as well as Medical Record Reviews evaluate the extent to which this process occurs. • The Plan has developed a number of quality improvement initiatives with the Plan's medical management, including the Coexisting Depression Program and the Psychotropic Medication Monitoring Among Members with Chronic Conditions Program, to promote this exchange of information. • The Department reviewed 20 case management files to evaluate how case managers coordinate care within the mental health system and between mental and medical health. Case management occurs only for two specific populations of plan enrollees: Healthy Families and PORAC benefit groups. Even with these populations, efforts are directed more toward use management than supportive case management for seriously mentally ill individuals, with the exception of post-hospitalization follow-up. • Case management of Healthy Families enrollees involves an immediate goal of expedited referral to the county for assessment to determine if the child meets criteria for SED status. If the child's evaluation results in SED "certification," the county assumes responsibility for coordination of ongoing mental health services and Plan case management ceases. The Plan retains responsibility for any authorizations and reviews of acute inpatient treatment, up to a 30-day-per-year benefit limit, and re-linkage of the enrollee with the county following discharge. ▪ The focus of case managers is on stabilization of mental health symptoms during episodes of acute psychiatric hospitalization. Case files showed evidence of expedited attempts to secure an evaluation by the county to determine whether Healthy Families enrollees met SED criteria. Additionally, case managers worked with the facility to link hospitalized patients with ongoing outpatient treatment. • Case managers proactively follow up at 30/90/180 days (7/30/90/180 days for patients whose hospitalization follows a suicide attempt) to ensure that discharged patients have continued in outpatient treatment. • The Plan has adopted nine clinical practice guidelines for mental disorders. The Identification and Treatment of Depressive

CONTINUITY AND COORDINATION OF CARE (Continued)	Disorder in the Primary Care Setting Guideline contains a referral process flow chart. Provider newsletters have notified clinicians of the availability of hard copies of the clinical practice guidelines and have given the Web site address where the guidelines can be found. • The Plan measures performance against the Depression Guideline, using the HEDIS Anti-Depression Medicaid Management measure that includes all prescribing practitioners, not just psychiatrists. • The plan has set up a Transition Assistance Unit whose function is to assist new enrollees entering the Plan and existing enrollees whose clinicians have left the Plan in transitioning their care. ▪ New group enrollees are notified during new group open enrollment process of their right to receive continuity of care. They receive a document titled Transition Assistance Program – Newly Covered Enrollees. Enrollees complete an application for a review that initiates the process**.** ▪ Enrollees affected by the departure of a provider from the plan are notified at least 60 days prior to the date that the provider leaves the plan. The notification to enrollees provides them an opportunity to request completion of covered services with a provider. Enrollees undergoing a course of treatment must initiate the request for transition assistance. This request is then reviewed by the plan Transition Assistance Unit.
DELEGATION	Not Applicable

A P P E N D I X C

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the onsite survey at the Plan's administrative office on May 31, 2005, through June 3, 2005:

BLUE CROSS OF CALIFORNIA, INC.	
Name	**Title**
Cheryl Noncarrow	President, WellPoint Behavioral Health
Michael Brase, MD	Vice President and Medical Director, WellPoint Behavioral Health
Sharon Ostach, LCSW	Director, Behavioral Health UM
Cliff Ridenour, LCSW	Director, Behavioral Health QM
Margaret Wooten	Director, Behavioral Health Networks
Paul Keith, MD	Associate Medical Director, Behavioral Health UM
Todd Cornett, MD	Associate Medical Director, Behavioral Health QM
Lori James, LCSW	Manager, Behavioral Health Quality Operations
Erin Mills	Regulatory Compliance
Peter Moren	Counsel
Sue Smith, RN	Manager, Behavioral Health UM
Annette Sandubrae, LCSW	Care Manager, Behavioral Health
Julie Rosen, LCSW	Care Manager, Behavioral Health
Mike Self	Manager, Large Group Operations, Customer Service
Betsy Burns	Specialty Care Manager, Behavioral Health
Laurire Amirpoor	Vice President, Pharmacy Services
Barbara Davenport	Specialty Care Manager, Behavioral Health

A P P E N D I X D

LIST OF SURVEYORS

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	**Title**
Dan McCord, MBA	Senior Health Care Service Plan Analyst
Pat Sturdevant	Counsel, HMO Help Center
Tom Gilevich	Counsel, HMO Help Center
Andrew George	Counsel, HMO Help Center

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Name	**Title**
Rose Leidl, RN	Contract Manager
Bernice Young	Program Director
Ruth Martin, MPH, MBA	Parity Survey Team Leader
Linda Woodall	Emergency Room Claims Surveyor
Erick Davis, MD, MPH, MBA	Utilization Management Surveyor
Daniel Kolb, PhD	Continuity and Coordination of Care Surveyor
Patty Nelson, RN, MS, CS, CPHQ	Access and Availability Surveyor

A P P E N D I X E

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCIES

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan has not established clear standards for after-hours care coverage and does not routinely monitor non-psychiatrist telephone and practice coverage arrangements. [Rule 1300.67.2(b)]

Citation:
Rule 1300.67.2(b)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees; …

(b) Hours of operation and provision for after-hour services shall be reasonable;

B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE

Deficiency 2: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4]

Citation:
Section 1371.4 (b) and (c)
(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

C. CONTINUITY AND COORDINATION OF CARE

Deficiency 3: For its commercial membership, the Plan does not have a structured approach to monitor the continuity and coordination of care that enrollees receive in the outpatient setting that allows the Plan to identify and assist individuals who could benefit from structured case management to improve mental health treatment outcomes, improve coordination between medical and mental health programs, and help enrollees find needed psycho-social-environmental support not within the scope of the Plan's benefits. [Rule 1300.74.72(g)(3)-(4)(A)]

Citation:
Rule 1300.74.72(g)(3)-(4)(A)
The Plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network.

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
CAP	Corrective Action Plan
DMH	Department of Mental Health
DOI	Department of Insurance
EOC	Evidence of Coverage
ER	Emergency Room
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases 9th Revision Clinical Modification
LCSW	Licensed Clinical Social Worker
MFT	Marriage and Family Therapist
MSA	Metropolitan Statistical Area
NATO	North American Testing Organization
PCP	Primary Care Physician
PMG	Primary Medical Group
PORAC	Police Officers Research Association of California
PPO	Preferred Provider Organization
UM	Utilization Management

A P P E N D I X G

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. Table 10 summarizes the survey activities and the corresponding timeframes.

TABLE 10: FOCUSED SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Focused Survey Onsite Visit Conducted	As needed
Preliminary Report due from the Department to the Plan	30–50 calendar days from the last day of the onsite visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Focused Survey Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the onsite visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the onsite visit

Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an adhoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-Onsite Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the onsite visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies, and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the onsite visit so that these will be readily available for the survey team.

Onsite Visit

During the onsite visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the onsite visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response, and if not, documents or other evidence provided by the Plan that the deficiencies have been corrected; and

(4) Evidence submitted by the Plan that remedial action has been initiated and is on the way to achieving compliance if the CAP cannot be fully implemented by the time the Plan submits its response, including a timeline for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's Web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the Web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's Web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report that will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response, and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the onsite survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.